December 10, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-075A

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region IV staff on this date.

Facility
CARTI-UAMS
Little Rock, Arkansas
License No.: 930-BP-04-09
Arkansas Agreement State Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: UPDATE - MEDICAL MISADMINISTRATION

DESCRIPTION:

On December 2, 2002, the Arkansas Department of Health (the Department) notified NRC's Operations Center of a reported medical misadministration involving iridium-192 in a high dose-rate remote afterloader. CARTI-UAMS, an Arkansas licensee, reported that the patient had been prescribed a series of treatments using iridium-192 in a high dose-rate remote afterloader. The first treatment had been administered on November 20, 2002. While reviewing the position verification film for the second treatment on November 27, 2002, the medical physics staff discovered that the treatment tandem had been positioned incorrectly within the cervical treatment cylinder during the treatment on November 20.

On December 9, 2002, the Department notified Region IV that they had completed their investigation of the reported medical misadministration. The Department conducted an onsite investigation on December 2, 2002 and the licensee provided a written report to the Department on December 5, 2002. It was determined that none of the intended treatment volume received dose from the first treatment. The treatment resulted in a dose of 5 gray (500 rad) delivered to a wrong treatment site. It was confirmed that the licensee informed the referring physician and the patient of the misadministration. The primary root cause was determined to be human error and the licensee has instituted new policies to prevent recurrence. The State considers this event closed.

Region IV received notification of this occurrence by facsimile from the State on December 9, 2002 . Region IV has informed OEDO, NMSS, OSTP and the Region's PAO and SLO.

This information has been discussed with the State and is current as of 11:00 a.m. on December 10, 2002.

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